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Treatment Escalation Plan (TEP) and Resuscitation Decision Policy

*(This policy applies to patients whose notes contain a valid TEP document or for the patient who presents at the Trust with a community raised TEP document)*

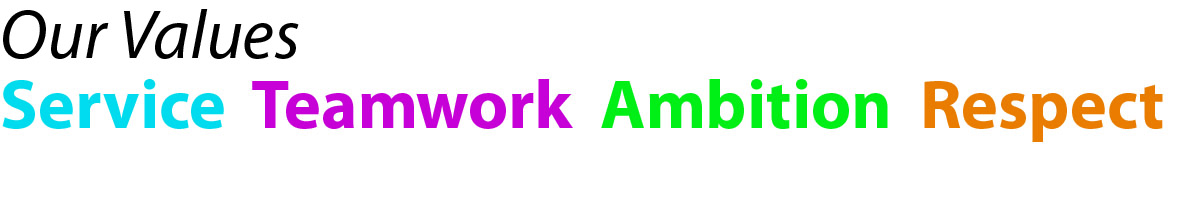
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| Document No. | *EDRMS000798* | Version No. | *2.0* |
| Approved by | *Policy Governance Group* | Date approved | *25/08/2015* |
| Ratified by | *Resuscitation Committee* | Date ratified | *15/06/2015* |
| Date Implemented | *07/09/2015* | Next Review Date | *15/06/2018* |
| Status | | *Approved* | |
| Target Audience | | All wards and departments within the Trust (Community & Acute sites)  All Trust employed medical /nursing and Allied Health Professionals (AHPs)  This policy applies to patients whose notes contain a valid TEP document, or for patient who present to the Trust with a community raised TEP document. | |
| Accountable Director | | Chief Nurse | |
| Policy Author/Originator | | Resuscitation Manager | |
| Implementation Lead | | Resuscitation Officer | |
| If developed in partnership with another agency, ratification details of the relevant agency | | South West Ambulance Services  Patient Information Group HUG  Wiltshire Care Home Forum  Wiltshire CCG End of life Programme Board | |

**Equality Impact**

Great Western Hospitals NHS Foundation Trust strives to ensure equality of opportunity for all service users, local people and the workforce. As an employer and a provider of health care, the Trust aims to ensure that none are placed at a disadvantage as a result of its policies and procedures. This document has therefore been equality impact assessed in line with current legislation to ensure fairness and consistency for all those covered by it regardless of their individuality. This means all our services are accessible, appropriate and sensitive to the needs of the individual.

**Special Cases**

This Policy is not applicable to children under the age of 16 but may support the decision making process for those aged between 16 and 18 years of age.



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# Instant Information – Decision Making Framework

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Yes

Yes

Treat as required. If, however, the patient wishes to discuss End of Life / resuscitation decisions, this should be respected

Yes

Has the patient anyone who could be consulted about their best interests? (Power of Attorney, Next of Kin)

No

Would I be surprised if the patient were to die in the next 6-12 months?

No

Is there an Advanced Decision to Refuse Treatment (ADRT)

No

Yes

Yes

Do they have a long term chronic disease? Should TEP/ End of Life wishes be considered?

Does the patient have the mental capacity to make this decision for themselves?

Yes

No

No

Independent Mental Capacity Advocate (IMCA) contacted? Are BEST INTEREST PRINCIPLES being adhered to?

Have all required discussions taken place? Patient, Relatives, Lasting Power of Attorney (LPA), Independent Mental Capacity Advocate (IMCA)

Treatment Escalation Plan

# Instant Information – Flowchart of Electronic Recognition and Recording of the Treatment Escalation Plan and Resuscitation Decision

TEP Alert raised from clinical / GP / Community Matron

Conversation Project Alert raised

IT Action

TEP Alert raised from clinical/ G.P / Community Matron email TEP.ResusDecision@gwh.nhs.uk

Conversation Project Alert raised

GP/ Consultant recognises that TEP/EOL conversation appropriate

Approach to review of EOL conversation and TEP for inpatient or clinic

Patient/family request for EOL/TEP conversation

Recognition

EOL/TEP Conversation with patient/ relative as appropriate

Conversation

Decision for TEP to be completed copy in notes original to patient/relatives as appropriate

Decision

Does patient have current TEP? If so review by senior clinician. If TEP appropriate copy form for notes and return to patient/relative on arrival

Check TEP alert on Medway system, if not please raise request email TEP.ResusDecision@gwh.nhs.uk

Procedure for patients arriving at hospital with current TEP

Check TEP alert is on the system, if not raise request email TEP.ResusDecision@gwh.nhs.uk

Complete discharge summary including Medway TEP decision

If patient leaves hospital review TEP for appropriateness. Ensure patient/relative has their copy, complete mandatory field on EDS discharge summary

Audit:

* Monthly report emailed to all GPs/ Community Matrons with regards to patients that have current TEP alerts
* TEP Lead To receive any updates of TEPs from Community Matrons/GP for Medway Alert updates
* Report to TEP Lead of those patients with TEPs that do not have a GP/Contact for review.

Procedure for patients leaving hospital

# Introduction and Purpose of the Document

This policy outlines the protocol for the making and recording of a Treatment Escalation Plan (TEP) and Cardio Pulmonary Resuscitation (CPR) Decision, to ensure effective communication of decisions made throughout the Great Western Hospitals NHS Foundation Trust (the Trust) and to support a holistic approach to patient care.

This Policy ensures that processes are in place to guide standards of clinical practice, to ensure appropriate training for relevant employees to enable them to make timely and acceptable Treatment Escalation and Resuscitation Decisions, to effectively communicate such decisions, and to accurately interpret the documentation in the event of a patient’s deterioration or suffering a cardiac or pulmonary arrest.

The purpose of this document is:

* To provide recommendations and guidance on the standards for clinical practice and training required in relation to resuscitation decisions by Trust employees.
* To provide a clear definition of terms.
* To provide a protocol for the making and recording of TEP & CPR Decisions within the Trust.

This policy provides a framework that aids the process of decision making with regard to end of life care, by identifying patients for whom cardiopulmonary resuscitation or other resuscitation measures would not be appropriate, and that this information has been communicated to all relevant parties. This policy seeks to ensure that clear and standardised documentation and communication of such decisions take place for each individual patient at an appropriate time.

## Glossary/definitions

The following terms and acronyms are used within the document:

|  |  |
| --- | --- |
| **ACP** | Advanced Care Planning |
| **ADRT** | Advanced Decision to Refuse Treatment (same as Advanced Decision) if completed correctly these are legal documents that reflect a patient’s wishes |
| **AHP** | Allied Health Professional |
| **CPR** | Cardiopulmonary resuscitation, which refers to chest compressions and ventilations |
| **CQC** | Care Quality Commission |
| **DNAR** | Do not attempt resuscitation |
| **DH** | Department Of Health |
| **DNARCPR** | Do Not attempt Cardiopulmonary Resuscitation |
| **EOL** | End Of Life |
| **ESR** | Electronic Staff Records |
| **EPaCCS** | Electronic Palliative Care Coordination System |
| **GMC** | General Medical Council |
| **GP** | General Practitioner |
| **HWLPA** | Health and Welfare Lasting Power of Attorney – a legally registered individual who has been asked been requested by the patient to make Health & Welfare decisions on their behalf at the point at which they lose their mental capacity to make any medical decisions for themselves. (Ref 25) |
| **ICD** | Implantable Cardioverter Defibrillators |
| **ICU** | Intensive Care Unit |
| **IMCA** | Independent Mental Capacity Advocate |
| **IV** | Intravenous i.e. Intravenous fluids or Intravenous Antibiotics a type of treatment |
| **JRCALC** | Joint Royal Colleges Ambulance Liaison Committee |
| **LEGAL GUARDIAN** | A person who has been selected to act as the primary caretaker of a child or minor. This person may be personally selected by the child's biological parents, or appointed by the court. |
| **LPA** | Lasting Power of Attorney |
| **MCA** | Mental Capacity Act (2005) |
| **Medway** | Patient Administration System (PAS) |
| **NICE** | National Institute for Health and Care Excellence |
| **NHS** | National Health Service |
| **NOK** | Next of Kin |
| **PPC** | Priority of Patient Care |
| **TEP** | Treatment Escalation Plan/ Resuscitation Decision Document |
| **WA** | Welfare Attorney – a legally registered individual who has been asked been requested by the patient to make Health & Welfare decisions on their behalf at the point at which they lose their mental capacity to make any medical decisions for themselves. (Ref 25) |

# Main Policy Content Details

This policy relates to the care of the adult patient and applies to all wards and departments across the Trust.

Where no explicit decision has been made in advance, there should be an initial presumption in favour of CPR and all other relevant treatment.

The TEP document is not a legally binding document but one that should guide the future care of the patient with regards to resuscitation decisions and the appropriate level of treatments previously agreed.

A TEP resuscitation decision does not override clinical judgement in the event that a reversible cause is identified which has led to the patient’s respiratory or cardiac arrest, and which does not match the circumstances envisaged by the clinician completing the TEP document.

This policy applies to patients whose notes contain a valid TEP document, or for patients who present to the Trust with a community raised TEP document.

The TEP document is designed to be patient-held and will travel with the patient. Copies of the documents will be kept in the patients’ notes for information, and an alert must be raised on Medway (the Trust’s patient administration system) (see section 2.21) in order for employees to identify those patients who have resuscitation decisions in place.

## When is it Appropriate to make a TEP?

### How to Recognise When a TEP should be Completed

Clinicians are encouraged, to identify where possible, when they feel a patient is approaching their final 6 – 12 months of life. The Department of Health’s report, “The Second Annual Report of the End of Life Strategy (2010)” (Ref 24) recommendation is that clinicians review these patients and this can be done by asking the following question, “Would you be surprised if this patient died within the next 6 –12 months?”,

For patients who prompt the answer “no” a clinical assessment should be made and the patient should be engaged in conversation to establish their understanding of their illness and prognosis, and their priorities and preferences for care. Once their wishes are known, if there is clinical indication to limit treatment, and following appropriate engagement with the patient and those important to them, a TEP should be completed in all cases. This is true in both the acute and community setting.

If the answer is “yes” a TEP may still be appropriate if this is the wish of the patient, although the expectation would be that most or all treatment interventions outlined on the form, would be appropriate for that patient.

The resuscitative interventions documented on the TEP form can include treatment interventions such as antibiotics, intravenous fluids, blood transfusions, ventilatory support, inotrope/vasopressor therapy, renal replacement therapy and CPR. The TEP document will be the form which will allow the documentation of those resuscitative interventions which are and are not appropriate for the individual patient.

A TEP can also be completed at the discretion of the General Practitioner (GP). The patient’s physical location should not be a bar to this process. The patient may prompt the completion of a TEP.

A Decision Making Framework flow chart describing the above can be found in Instant Information -1.

### The Conversation Project

Within the hospital employees should, at all stages of a patient’s care, encourage discussion with regards to end of life wishes. It is the responsibility of all clinical employees to identify those patients who wish to discuss their end of life wishes, ideally long before there is a medical crisis.

Too many people die in a manner they would not choose. The Conversation Project offers people the tools, guidance and resources they need to begin talking with their family, friends and clinicians about their wishes and preferences either in a hospital or GP setting, or even around the kitchen table.

The Conversation Project, as noted in the End of Life Care Strategy (Ref 17), does not promote any specific preference for end of life care; instead it seeks to encourage and support people in expressing their own wishes for care.

### Treatment plans for Resuscitation (to Cardiopulmonary Resuscitate or not)

The decision to use any treatments should be based on the balance of burden, risks and benefits to the individual receiving the treatment, and this principle applies as much to CPR as to any other treatment.

Healthcare professionals have an important role in helping patients to participate in making appropriate plans for their future care in a sensitive, but realistic manner, making clear whether or not attempted CPR could be successful. Helping patients to reach a clear decision about their wishes in respect of CPR should be regarded as a marker of good practice.

Decisions about CPR must be made on the basis of an individual assessment of each patient’s case.

It is important not to discriminate, for example, on the basis of age, disability or a professional’s subjective view of a patient’s quality of life.

The Human Rights Act 1998 (Ref 19) sets out clear guidance that is particularly relevant to CPR, including the rights:

* To life (Article 2),
* To be free from inhuman or degrading treatment (Article 3),
* To respect for privacy and family life (Article 8),
* To freedom of expression, which includes the right to hold opinions and to receive information (Article 10),
* To be free from discriminatory practice in respect of these rights (Article 14).

The spirit of the Act, which aims to promote human dignity and transparent decision making, is reflected in these ethical considerations:

* The likely clinical outcome, including the likelihood of successfully re-starting the patient’s heart and breathing for a sustained period, and the level of recovery that can realistically be expected after successful CPR.
* The patient’s known or ascertainable wishes, including information about previously expressed views, feelings, beliefs and values.
* The patient’s human rights, including the right to life and the right to be free from degrading treatment.
* The likelihood of the patient experiencing severe unmanageable pain or suffering.
* The level of awareness the patient has of their existence and surroundings.

### Acting in the Patient’s Best Interests

All treatment and care that is appropriate for a patient will be offered at all times as it is always the Health Professional’s duty to act in the patient’s best interests.

For the majority of patients the over-riding aim is to return them to their pre-illness level of health, or as near to it as possible. Nevertheless, it is not an appropriate goal of medicine to prolong life at all costs with no regard to quality or the burdens of treatment on the patient. Moreover, to begin therapeutic intervention that the patient will clearly not survive is not in their best interests. This implies that not all treatment interventions are appropriate for every patient, every time.

There will be instances when a clinical decision has been made that a patient is dying, or will go on to die within hours or days. It is of paramount importance to ensure the comfort of the patient, and to be sure that the patient and their family/carers, where applicable, understand what is happening and are able to plan for their future care.

For all of these patients, the Trust must ensure that the appropriate resuscitation decisions, which respect the patient’s rights and choices, are in place, understood by all relevant employees, and where applicable, families/carers, and are accessible to those who need them. These patients must have a clear and explicit resuscitation plan and this must be recorded in their medical notes.

The General Medical Council guidance, “Treatment and care towards the end of life” (Ref 6), acknowledges that the most difficult and sensitive decisions in the patient’s end of life care are often those around starting, or stopping, potentially life prolonging treatments such as CPR. Such decision making remains important, and should be recorded as part of advance care planning.

Engaging patients and, where appropriate, families, in advance care planning puts them back at the centre of their care. The importance of such an approach is recognised in the Royal College of Physicians 2009 guide to advance care planning, which states: *“at the core of current health and social care are efforts to promote patient-centred care, offer choice, and the right to consent to or refuse treatment and care offered…Advance care planning will help.” (Ref 8)*

The NHS End of Life Care Strategy (Ref 7) stipulates that all people approaching the end of their life, need to have their needs assessed, their wishes and preferences discussed, and an agreed set of actions reflecting the choices they make about care recorded in a care plan. This should be shared with families and relatives where applicable.

The TEP is a document where appropriate treatment options for the patient are laid out with a note made of those resuscitative interventions which may be appropriate. This will be discussed with the patient, and families/carers where applicable, and it may be appropriate for this discussion to be had early in their illness as some patients may deteriorate quickly and, as such, may not have capacity to make specific decisions about future life sustaining treatments at that time. It is also appropriate for the TEP document to be reviewed and updated as circumstances change.

The TEP should be initiated and completed in any of the possible healthcare settings within the Trust’s acute or community sites. The TEP recognises the need for early identification of those patients who, despite active medical treatment, have the potential to deteriorate to a point of needing resuscitative interventions. If the patient lacks capacity to participate in decision making, a Health & Welfare lasting Power of Attorney (HWLPA) (where one exists) and the family and next of kin must be engaged (see sections 2.5) Adults who lack capacity).

### Advance Care Planning

In cases where there is an identifiable risk of cardiac or respiratory arrest, it is desirable to make decisions about CPR in advance whenever possible. There should be a full clinical assessment of the chances of a successful outcome and the clinician should gather and consider all of the relevant information relating to the patient’s wishes and clinical condition.

Ensuring that discussion takes place about the TEP and resuscitation choices and a decision is made in advance, where possible, is preferable to making decisions in a crisis when there may be insufficient time.

End of life care planning must be a process which fully involves the patient and/or family /carers at all stages.

Patients may access hospital services at various stages of their illness and receive care, treatment and support from a range of services.

Those patients who may be at risk of losing their mental capacity as their end of life approaches should be encouraged to consider obtaining a Health and Welfare Lasting Power of Attorney or discuss their decisions with their family/carers.

### Changes in Patient Condition

The TEP document should be reviewed by a senior doctor as the patient’s condition changes, particularly if there is a return of mental capacity. If there is a change in decision, the original document must be clearly scored through, signed and dated. It should then be filed to the rear of the notes. A new TEP and resuscitation decision form showing the current decision must be completed and a copy placed in the front of the medical notes, and the original given to the patient or relatives as they leave hospital, if appropriate.

All decisions need to be recorded, dated, and justified in the notes, be clearly communicated to all teams and be discussed with the patient and their family/carer where applicable. The TEP form is intended to be patient-held and is a Countywide recognised document. A TEP form introduced during one hospital admission must be reviewed at any and each subsequent admission to hospital by the medical team responsible for the patient’s new episode of care.

The TEP should accompany the patient on discharge. To avoid unnecessary distress it is important that the patient, and their family/carers as appropriate, have been involved in the TEP discussions prior to discharge. A photocopy of the TEP should be filed in the patient’s clinical records on discharge.

Whilst it is intended that the TEP document is to be patient-held, it is appreciated that this might not be suitable for all circumstances and that alternative arrangements may be necessary. (e.g. the form to be held by family, carer, G.P. or Care Home.)

For patients who are discharged using ambulance transport, the crews should be informed that the patient is receiving End of Life care or has a TEP form in place. The original document should be sent with the patient, or if that is not appropriate a copy of the document given to the ambulance crew. Any resuscitation decision made with the patient and recorded on the TEP will apply both on transit in the ambulance and at the community setting until reviewed by the G.P.

### Non-discriminatory Decision Making

Any resuscitation or TEP decision must be tailored to the patient’s individual circumstances. Decisions must not be made on the basis of assumptions, or based solely on factors such as the patient’s age, disability, or on a professional’s subjective view of a patient’s quality of life. Blanket policies that deny treatment to groups of patients, for example to all patients above a certain age, are unethical and unlawful.

When assessing whether attempting CPR may benefit the patient, decision makers must not be unduly influenced by any of their own pre-existing (negative or positive) views about living with a particular condition or disability. The key issue to consider is not the decision-maker’s view of the patient’s disability, or the level of recovery that can reasonably be expected following resuscitation measures, but an objective assessment of what is in the best interests of the patient, taking account of all relevant factors.

### Summary of the reason the decision has been made

There must be a brief explanation of the reason(s) ***e.g. “serious co-morbidities” “very poor prognosis”.*** Single words alone i.e. *“futile”, “elderly”, “frailty”, “sleepy”* are not sufficient. A more extensive explanation can be documented inside the patient’s notes if necessary.

Clinician’s should be reminded that the brief explanation given on the TEP document will guide future decisions and treatments for the patient.

### Suspending Resuscitation Decisions

Uncommonly, some patients for whom a TEP/Resuscitation decision has been established may develop cardiac or respiratory arrest from a readily reversible cause such as choking, induction of anaesthesia, anaphylaxis or blocked tracheostomy tube. In such situations CPR would be appropriate, whilst the reversible cause is treated, unless the patient has specifically refused intervention in these circumstances. In addition to reversible causes, it may be appropriate to temporarily suspend a decision not to attempt CPR during some procedures if the procedure itself could precipitate a cardiopulmonary arrest – for example, cardiac catheterisation, pacemaker insertion or surgical procedure.

### Review

Decisions about CPR must be reviewed whenever changes occur in the patient’s condition, if the patient is transferred to the care of a new clinician, discharged from a hospital, or at the patient’s expressed wishes. The frequency of review should be determined by the health professional in charge of the patients care, and will be influenced by the clinical circumstances of the patient.

It is important to note that the patients’ ability to participate in decision-making may change with changes in their clinical condition. It is not usually necessary to discuss CPR with the patient each time the decision is reviewed, although where a patient has previously been informed of a decision and it is subsequently changed, they should be informed of the change of decision and the reason for it.

**Any CPR decision made at the time of initial admission of a patient to hospital should be reviewed by the most senior clinician in charge of the patient’s care at the earliest opportunity.**

There may also be occasions when an initial decision has been made to attempt CPR but the patient’s clinical circumstances change subsequent to that decision and it is no longer clinically appropriate to perform CPR when the patient suffers cardiorespiratory arrest as it would not be successful.

## Requests for CPR Where the Burdens May Outweigh the Benefits

Some patients may ask for CPR to be attempted, even though the multidisciplinary medical team believe that it should not be, as it would not have a realistic chance of being successful, or would not be in the patient’s best interests. Realistic information must be provided sensitively to patients about the nature of CPR and the likely risks, including the risk of likely failure and, if successful, of long term neurological damage.

These difficult situations are a potential source of confusion. Doctors cannot be required to give treatment contrary to their clinical judgement, but should be willing to consider and discuss patients’ wishes to receive treatment, even if it offers only a very small chance of success or benefit. Where CPR has a reasonable chance of successfully re-starting the heart and/or breathing for a sustained period, and a patient has decided that the quality of life that can reasonably be expected is acceptable to them, their wish for CPR should be respected.

In the unusual circumstance in which the doctor responsible for a patient’s care feels unable to agree to the patient’s expressed wishes for attempted CPR, or where there is lack of agreement within the healthcare team, seeking a second opinion is recommended so that the patient may be given an opportunity to review their decision in the light of further advice. Transfer of the patient’s care to another doctor or team can be considered if there is still a lack of agreement, and it is feasible. In exceptional circumstances, where there is on-going disagreement, it may be necessary to seek legal advice.

## Refusals of CPR by Adults with Capacity

Clearly patients will lack capacity at the time of suffering cardiac or respiratory arrest but anticipation of the possible occurrence of this event may enable patients to decide in advance that they do not want CPR to be attempted.

It is well established in law and ethics that adults with capacity have the right to refuse any medical treatment, even if that refusal results in their death. Where healthcare teams believe that CPR may be successful in re-starting the patients’ heart and breathing for a sustained period, discussion should take place with the patient to determine their views and wishes regarding CPR. If the patient decides that they do not wish to have CPR attempted, this should be documented carefully in the hospital, GP or health establishment’s records and on the TEP form and steps should be taken to ensure that this is communicated to those who need to know (see section 2.2).

Patients are not obliged to justify their decisions, but health professionals usually wish to discuss the implications of a refusal of treatment with patients in order to ensure that the decision is based on accurate information and not on any misunderstanding. However, they must take care not to pressure patients into accepting treatment that they do not want. Some people may be happy for their refusal of CPR simply to be documented on the TEP form by the healthcare team. In England and Wales, unless these records are signed by patients and the signature is witnessed and complies with the current Mental Capacity Act (Ref 26), they are unlikely to meet the legal criteria for a valid advance decision and so some patients may prefer to make a formal, written advance decision.

Similarly, if patients are not currently being treated in a healthcare establishment and they want to ensure that their wishes are respected, they may decide to make a formal, written advance decision following the criteria stipulated in the Mental Capacity Act 2005 (England and Wales) (Ref 3). The onus is on patients to ensure that healthcare teams are aware of the existence and content of any advance decision.

## Advance Decisions Refusing CPR

CPR must not be attempted if it is contrary to valid and applicable advance decisions made when the patient had capacity (see below for criteria for validity). In England and Wales, advance decisions are covered by the Mental Capacity Act 2005 (Ref 26).

The Act confirms that an advance decision refusing CPR will be valid and therefore legally binding on the healthcare team, if:

* The patient was 18 years old or over and had capacity when the decision was made.
* The decision is in writing, signed and witnessed.
* It includes a statement that the advance decision is to apply even if the patient’s life is at risk.
* The advance decision has not been withdrawn.
* The patient has not, since the advance decision was made, appointed a HWLPA to make decisions about CPR on their behalf.
* The patient has not done anything clearly inconsistent with the terms set out in the advance decision.
* The circumstances that have arisen match those envisaged in the advance decision.

If an advance decision does not meet these criteria but appears to set out a clear indication of the patient’s wishes, it will not be legally binding but should be taken into consideration in determining the patient’s best interests.

## Assessing Validity and Applicability of an Advance Decision after an Individual has Lost Capacity

Although advance decisions often do not come to light until the individual has lost capacity, there should be a presumption that the individual had capacity when an advance decision was made, unless there are grounds to suspect otherwise.

Health professionals must decide whether the advance decision is applicable to the circumstances that have arisen. Particular care will be needed where an advance decision has not been reviewed regularly, or updated, and attention should be given to any relevant clinical developments or changes in the patient’s personal circumstances since the decision was made. For example, patients may have taken actions, or made other important decisions, that indicate that they have changed their minds.

Where there is genuine doubt about the validity and applicability of an advance decision and when time permits, further enquiries should be made and, if necessary, an application made to the Court of Protection (in England and Wales).

In an emergency, where there is no time to investigate further, the presumption should be in favour of CPR if this has a realistic chance of prolonging life. If it is agreed that an advance decision is invalid, or not applicable, the reasons why it is considered invalid or not applicable should be documented.

### Adults who Lack Capacity and have no Family, Friends or other Advocate whom it is Appropriate to Consult

If the patient is incapacitated then their Health & Welfare Lasting Power of Attorney (HWLPA) (6.3), if one has been appointed, or their nearest relative or carer must be involved in any decision with regard to resuscitation. Failing this an Independent Mental Capacity Advocate (IMCA) must be consulted under the terms of the Mental Capacity Act 2005 (Ref 3). Please also refer to Mental Capacity Act 2005 policy and procedure (Ref 2) when dealing with the incapacitated adult.

The patient may have already indicated their wishes in an Advance Care Plan (ACP), Preferred Priorities of Care (PPC) form or Advance Decision to Refuse Treatment (ADRT). An ACP or PPC form outlines the patient’s wishes in case of clinical deterioration. ACP and PPC are not legally binding and are advisory to the actual care given. This is distinct from an ADRT or an advance decision. If valid, applicable, and signed by the patient, the ADRT/ advance decisions are legally binding.

Under the terms of the Mental Capacity Act (Ref 3), if the patient has made a Health & Welfare Lasting Power of Attorney, they will be entitled to make health-related decisions on the patient’s behalf once the patient loses capacity to make their own decision and for this reason the Welfare Attorney must be consulted. A Welfare Attorney may be able to refuse life-sustaining treatment on behalf of the patient if this power is included in the original Health and Welfare Lasting Power of Attorney.

In England, people close to patients, other than a Welfare Attorney, are not legally entitled to give consent to medical treatment on behalf of an adult who lacks decision making capacity, nor can they insist on treatment or non-treatment. Doctors have authority to act in their patients’ best interests where consent is unavailable.

The TEP (like the previous DNAR Document) is not legally binding. It is a signpost to the care to be given; clinical judgement will still take precedence.

The Mental Capacity Act 2005 (Ref 3) requires an independent mental capacity advocate (IMCA) to be consulted about all decisions concerning ‘serious medical treatment’ where patients lack capacity and have nobody to speak on their behalf, and the decision is to be made by an NHS body or Local Authority.

The definition of serious medical treatment includes circumstances where ‘what is proposed would be likely to involve serious consequences for the patient’. It can be argued that a decision not to attempt CPR because it will not work will not have ‘serious consequences’ for the patient, because the patient will die with or without attempting CPR. For this reason, in the Trust’s view, an IMCA does not need to be called when it is clear to the medical team that CPR would not re-start the patient’s heart and breathing for a sustained period.

Nevertheless, neither the Act, nor the code of practice, differentiates between decisions made purely on clinical grounds (i.e. because the treatment is unable to achieve its clinical aim) and those that involve broader best-interests considerations, and so it needs to be acknowledged that there is still some uncertainty in this area.

Where there is genuine doubt about whether or not CPR would have a realistic chance of success, or if a DNACPR decision is being considered on the balance of benefits and burdens, in order to comply with the law an IMCA must be involved in every case. If a DNACPR decision is needed when an IMCA is not available, (for example at night or at a weekend), the decision should be made and recorded in the patient’s health record. The decision should be discussed with an IMCA at the first available opportunity.

An IMCA does not have the power to make a decision about CPR, but must be consulted by the clinician in charge of the patient’s care as part of the determination of the patient’s best interests.

### Adults who Lack Capacity

The sections above have set out the level of involvement of patients, and those close to them, in making or guiding decisions about CPR. This will vary depending on whether the decision not to attempt CPR is based solely on medical factors (i.e. CPR would not be successful), or on the balance of benefits and burdens, which involves a broader ‘best interests’ judgement.

The following sections explain who should be consulted when adults lack capacity and explains the main provisions of the Mental Capacity Act 2005 (England and Wales) (Ref 3) concerning proxy decision-makers.

Decision-making capacity refers to the ability that individuals possess to make decisions, or to take actions, that influence their life, from simple decisions about what to have for breakfast to far-reaching decisions about serious medical treatment, for example CPR. In a legal context it refers to a person’s ability to do something, including making a decision, which may have legal consequences for the person or for other people.

Patients over 16 years of age are presumed to have capacity to make decisions for themselves, unless there is evidence to the contrary. Individuals are, however, considered legally unable to make decisions for themselves if they are unable to:

* Understand the information relevant to the decision.
* Retain that information.
* Use or weigh that information as part of the process of making the decisions, or
* Communicate the decisions (whether by talking, using sign language, visual aids or by other means).

### Patients with a Welfare Attorney or Court-Appointed Deputy or Guardian

If patients lack capacity and have a HWLPA or Legal Guardian, this person must be consulted about CPR decisions. In England and Walesthe Mental Capacity Act 2005 (Ref 3) allows people over 18 years of age who have capacity to make a Health And Wellbeing lasting power of attorney or appoint a Welfare Attorney, to make health and personal welfare decisions on their behalf once such capacity is lost. Before relying on the authority of this person, the healthcare team must be satisfied that:

* The patient lacks capacity to make the decision.
* A statement has been included in the HWLPA specifically authorising the Health & Welfare Attorney to make decisions relating to life-prolonging treatment.
* The HW LPA has been registered with the Office of the Public Guardian.
* The decision being made by the attorney is in the patient’s best interests.

In England and Walesneither Health & Welfare Lasting Power of Attorneys nor deputies can demand treatment that is clinically inappropriate, but where CPR may be able to re-start the heart and breathing for a sustained period, and a decision on whether or not to attempt CPR is based on the balance of benefits and burdens, their views about patients’ likely wishes must be sought.

Where there is disagreement between the healthcare team and an appointed Health and Welfare Lasting Power of Attorney regarding TEP and cardiorespiratory arrest decisions, and this cannot be resolved through discussion with a second clinical opinion, the Court of Protection may be asked to make a declaration.

If it is felt the HWLPA is not acting in the patient’s best interest the Office of the Public Guardian must be informed along with the local Safeguarding Team.

More information about Health and Welfare legal powers of Attorneys and the Mental Capacity Act 2005 can be found in the Mental Capacity Act 2005 Policy and Procedure (Ref 2).

### Adults who Lack Capacity, have neither an Health and Welfare Legal Power of Attorney or an Advance Decision but do have Family or Friends

Where a patient has not appointed a HWLPA, or made an advance decision, the treatment decision rests with the most senior clinician in charge of the patient’s care. Where CPR may re-start the patient’s heart and breathing for a sustained period, the decision as to whether CPR is appropriate must be made on the basis of the patient’s best interests. In order to assess best interests, the views of those close to the patient should be sought, unless this is impossible, to determine any previously expressed wishes and what level or chance of recovery the patient would be likely to consider of benefit, given the inherent risks and adverse effects of CPR.

In England and Walesthe Mental Capacity Act 2005 (Ref 3) requires that any best-interests decisions must include seeking the views of anyone named by the patient as someone to be consulted, anyone engaged in caring for the person or interested in the patient’s welfare.

Under the Act, all healthcare personnel, for example doctors, nurses and ambulance crew, must act in the best interests of a patient who lacks capacity.

## Children and Young People (aged 16-18) Treatment Plans for Resuscitation

Ideally, clinical decisions relating to young people should be taken within a supportive partnership involving the patients, their families and the healthcare team. Where CPR may re-start the heart and breathing for a sustained period, but there are doubts about whether the potential benefits outweigh the burdens, the views of the young person should be taken into consideration in deciding whether resuscitation should be attempted. The Medical Director may need to be contacted and legal advice may be sought in the event of a dispute.

Young people with capacity are entitled to give consent to medical treatment, and where they lack this capacity, it is generally those with parental responsibility who make decisions on their behalf.

In England, Wales and Northern Ireland, refusal of treatment by competent young people up to the age of 18 is not necessarily binding upon doctors since the courts have ruled that consent from people with parental responsibility, or the court, still allow doctors to provide treatment. Where a young person with capacity refuses treatment, the potential harm caused by violating the young person’s choice must be balanced against the harm caused by failing to give treatment.

Throughout the UK, if the healthcare team believes that they should attempt CPR for a competent young person who has indicated that they do not want this, legal advice should be sought. Usually, it is possible to reach agreement on whether or not CPR should be attempted if a child or young person suffers respiratory or cardiac arrest. If there is disagreement between the patient, those with parental responsibility and the healthcare team despite attempts to reach agreement, legal advice should be sought.

Parents cannot require doctors to provide treatment contrary to their professional judgement, but doctors should try to accommodate parents’ wishes where there is genuine uncertainty about the young person’s best interests. If legal advice is required, this should be sought in a timely manner.

For more information regarding Paediatric resuscitation decisions please refer to the Paediatric Resuscitation Policy (Ref 27).

## Consultation with the Family regarding Patients who Lack Capacity

Where patients lack capacity and their views on involving family and friends are not known, doctors may disclose confidential information to people close to the patient, where necessary to discuss the patient’s care, and is not contrary to the patient’s interests. Where there is a HWLPA, deputy, or Legal Guardian involved in the discussions, relevant information should be provided to them, to enable them to fulfil their role.

In cases where the views of family and friends have no legal status in terms of actual decision making, it is good practice to involve those people close to the patient in discussions as this will help inform the clinician’s decisions. Where IMCAs are involved they have a legal right to information, including access to the relevant parts of the patient’s records, in order to enable them to carry out their statutory role.

The National End of Life Care Programme “Route to Success” (6) (Ref 12) asks that NHS Trusts ensure that there is a communication system in place to keep all members of the multidisciplinary team across all sectors fully informed of decisions relating to TEP. As part of the patient’s discharge letter, the patient’s GP should be informed of all TEP discussions. This can be achieved through a mandatory field on the patient’s discharge letter, as well as an alert that can be added to the Medway patient administration system to alert employees. Please see Instant Information 2- Flowchart of Electronic Recognition and Recording of the Treatment Escalation Plan and Resuscitation Decision.

## Confidentiality

If patients have capacity, their agreement must always be sought before sharing information with family and friends. It may also be helpful to ask patients with capacity who they want, or do not want, to be generally involved in decision-making should they become incapacitated (although it should be made clear that unless this person is formally appointed as a HWLPA, their role will be limited to providing information for the health professional who will ultimately make the decision regarding the patient’s treatment). Refusal by a patient with capacity to allow information to be disclosed to family or friends must be respected, and that decision documented appropriately in the medical notes and on the TEP form.

## Information for Patients

Dying Matters (Ref 13) encourages healthcare providers to make available the written information presented within TEP policies which, should be included in the general literature provided to patients about healthcare organisations, including hospitals, hospices, general practices, ambulance services and care homes. Such information should be readily available to all patients and to people close to the patient including relatives and partners. Its purpose is to de-mystify the process by which decisions are made, and should make clear that for most patients the question will not arise. Information should reassure patients of their part in decision making, what facilities are available, and when it is likely that CPR would be successful. Nevertheless all patients and those close to them can ask for time to be set aside to discuss any aspects of a TEP, should they wish to. (See patient information leaflet Cardiopulmonary Resuscitation (CPR) information leaflet (Ref 20)).

Patients who are on an End of Life Pathway, having been identified as dying, will usually have a Treatment Escalation Plan in place which will need to be communicated to the family and carers.

If patients indicate that they do not wish to discuss these issues, then this should be respected. Where a TEP is completed and there has been no discussion with the patient because he or she has indicated a clear desire to avoid such discussion, this must be documented in the health records.

The onus is upon clinical employees to inform patients regarding the likely survivability following commencement of any particular resuscitative intervention, and what the burdens and benefits of intervention entail. The TEP decision record is designed to be the template for a positive discussion beginning with the less invasive treatment interventions that will be offered, but perhaps concluding with those more invasive treatment measures that would not be in the patient’s best interests, and therefore not offered.

## Written Information Regarding TEP/Resuscitation Decisions Available to Patients

Written information is available for patients and their families in the form of CPR patient information leaflets (Ref 20) and also this TEP/Resuscitation Policy. Patients should be encouraged to see such information as a routine part of their care planning to cover all contingencies rather than an intimation of particular risks to themselves.

Information should reassure patients of their central role in the decision making processes involved in the completion of a TEP. It shouldmake clear that, for most patients, the question of acting on the decisions documented may not arise.

If patients require further information, they should be supported to access this via members of the multidisciplinary healthcare team or their local Patient Advice & Liaison Service (PALS). All leaflets are available through the normal ordering process, and must be available in all clinical areas.

## Responsibility

The overall responsibility for making a decision regarding TEP/Resuscitation rests with the Consultant or General Practitioner in charge of the patient’s care.

This must be made after appropriate consultation and consideration of all aspects of the patient’s condition. Decisions must be taken in the best interests of the patient, an assessment of which should include probable clinical outcome, and the patient’s known wishes, which may include an Advanced Directive.

Medical employees must communicate in a language that patients can understand bearing in mind different learning abilities.

In the absence of the Consultant, a senior member of the team may make a TEP/Resuscitation decision. Out of hours, in the absence of a senior doctor, the doctor on call may undertake the decision in consultation with the Consultant on call, or GP and nursing employees. In all cases where the Consultant in charge, or GP has not been involved in the TEP/Resuscitation decision, then his/her agreement should be obtained at the earliest opportunity. The decision should not preclude undertaking other aspects of care, and should be noted on the TEP decision record.

Foundation Year 1 and 2 doctors or specialist competent registered practitioner i.e. Specialist Nurses must not make a TEP/Resuscitation Decision. However they may have the discussion with the patient and their family and complete the decision record prior to the GP / Consultant signing. If it is felt more appropriate for a competent registered Practitioner Nurse or competent Junior Doctor to carry out the discussion, this must only be carried out with the agreement and knowledge of the patient’s Consultant /GP.

TEP/Resuscitation decisions can be made by other trainee doctors or competent senior nursing staff in the unavoidable absence of a Consultant/GP, provided they have the prior authority of their supervising Consultant/GP to make decisions of this kind. The trainee Doctor or competent senior nurse must involve a Consultant/GP in this decision within 24 hours.

**All TEP forms must ultimately be signed or counter signed by the Consultant or GP who is in charge of the patient’s care.**

## Responsibility for Decision-Making

Teamwork and good communication are of paramount importance. Where care is shared, for example between the hospital and general practice or between general practice and a care home, the health professionals involved must discuss the issue with each other, and with other members of the healthcare team.

There must be shared responsibility for deciding about the likelihood of a successful outcome from CPR, and discussions between teams regarding those patients who lack capacity, where a balance of benefits and burdens is needed. Nevertheless, one individual needs to take charge of ensuring that the decision is made properly, is recorded, and is conveyed to all those who need to know it, including locum workers. In all cases this will ultimately be the Consultant or patients GP.

## Recording Decisions

Any decision about whether or not to attempt CPR must be readily accessible to all health professionals who may need to know it, including employees of hospitals, hospices and nursing homes, GPs and other community health professionals, out-of-hours medical services, and ambulance employees. **All adults should have these decisions recorded on a TEP** decision record**.**

*The patient’s healthcare record should contain a resuscitation status form (TEP)* which demonstrates:

* Clear documentation of the decision.
* Who is responsible for having the discussion.
* Who is the lead clinician at the time the decision was made.
* Date of decision.
* Reasons for the decision.
* The name and position of the person responsible for making the decision.

*If the patient’s Resuscitation status is reviewed and changed:*

* A new TEP form must be completed.
* The previous form must be kept in the medical notes and scored through for future reference but clearly marked as superseded (see section 2.15).

Patients’ individual treatment plans for resuscitation must be recorded with clear, documented evidence of the patient’s decision for CPR or Not. The documentation must include how the decision was made, date, and reason for the decision. The documentation must also include the name and position of the decision maker plus the details of the competent registered professional who has had the conversation and completed the form prior to it being signed by the Consultant or GP. A copy or the original TEP document must be held in the patient’s records and should be easily identifiable and accessible in the case of an emergency.

On discharge from the hospital the original TEP document should go with the patient, where appropriate, as this is their property. (For those who choose not to take their form (see section 2.21)

It is the responsibility of the Consultant to facilitate the request for a TEP Alert to be raised on the patient’s Medway (PAS) record this can be done by sending an email to [TEP.ResusDecision@gwh.nhs.uk](mailto:TEP.ResusDecision@gwh.nhs.uk). The email should contain the patient’s name, NHS number, Hospital number and date of birth. This is carried out in line with the PAS/EPR Patient Alert Policy (Ref 23).

Throughout the Trust if a child has been deemed not suitable for Cardiopulmonary Resuscitation then the Trust Child DNA-CPR form must be completed. (Details of documentation can be sourced from the Paediatric Resuscitation Policy (Ref 27).

## Discussions with Patients and Relatives/Carers/Friends

Discussions around advanced planning will usually be between an appropriate, experienced and competent registered practitioner and the patient and/or their family/relatives/carer. The names and relationships of those involved in the discussions must be noted. A more detailed description of such discussion should be recorded in the patient’s clinical notes where appropriate.

The date and time of reaching a TEP/Resuscitation decision must be clearly and fully documented using the Treatment Escalation Plan and Resuscitation Decision Record (see Appendix C) and must include the clinical justification, when the TEP would be applicable and the documented discussion with the patient. The reasons and circumstances of any TEP/Resuscitation decision must be reviewed regularly i.e. on ward rounds. Review of any TEP/Resuscitation decision is essential if there is a material change in the patient’s clinical condition. Any changes to the TEP must be fully documented on the TEP document and in the patient’s notes.

Nursing employees are encouraged and expected to raise the issue of the resuscitation status of any given patient with the medical team at ward rounds, or at other times when appropriate. The resuscitation status of each patient must be communicated at each handover. Communication of the resuscitation status to any employees involved with the clinical management of the patient, e.g. radiographers, physiotherapists etc. is also essential to ensure appropriate measures are able to be undertaken should deterioration of condition happen outside of the patients ward area.

If a patient, family or employee is not happy with the TEP/Resuscitation decision, then a second opinion from another experienced Consultant/General Practitioner should be sought as soon as possible. The occurrence and outcome of that consultation should be reported in the notes. If conflict remains between the patient and clinicians the Medical Director must be informed.

The TEP must be reviewed if the patients clinical status changes, or when the patient care environment changes. A conversation must always occur to confirm with the patient, and their family when appropriate, their understanding of the TEP decision and confirm its particulars remains relevant. It must not be seen as a mechanism to reduce conversations/discussions of end of life care/advanced planning, particularly as these conversations need to evolve with the patient’s disease process.

## Review of the TEP

Decisions concerning TEP must be reviewed in the light of any changes in:

* The patient’s clinical condition.
* The patients expressed wishes.
* The patient is transferred from one lead clinician to another.
* The patient is admitted from home or discharged home.
* Any changes needed that require the original document to be cancelled and a new TEP form completed.

## Cancellation of a TEP Form

To cancel a TEP form, complete the following actions:

* Cross it through diagonally and write “CANCELLED” across the decision record.
* Include the date it was cancelled.
* Include the Name and Signature of the Clinician making the decision.
* If an Alert is on the Medway (PAS) patient records, send an email to [TEP.ResusDecision@gwh.nhs.uk](mailto:TEP.ResusDecision@gwh.nhs.uk) to cancel the Alert. The email should contain the patient’s name, NHS number, Hospital number and date of birth.

## Organ Donation

The choice of becoming an organ and/or tissue donor must be offered to every patient where possible. Asking people their views on organ donation must be an integral part of the discussion of treatment escalation plans. As well as encouraging the open discussion of the individuals’ wishes with close family members, clinicians must also promote the completion of the online Organ Donor Register (Ref 14) where donation has been agreed.

There are very few absolute contraindications to organ donation, and even fewer to tissue donation, so offering the choice of becoming an organ and/or tissue donor must be given to everyone.

Please refer to the Identification, Referral and Approach to Families of Potential Organ and Tissue Donors Policy (Ref 5) and the Transplant Specialist Nurse for Organ Donation, contact details found in the above policy (Ref 5).

## Deactivation of Implantable Cardioverter Defibrillators

Implantable Cardioverter Defibrillators (ICD) implanted patients may later develop terminal illness due to worsening of their underlying heart disease or other chronic non cardiac disease. Terminally ill patients are more likely to develop conditions such as hypoxia, sepsis, pain, heart failure and electrolyte disturbances, predisposing them to tachyarrhythmia’s and thus increasing the risk of shock therapy. Shocks can be physically painful and psychologically stressful without actually prolonging a life of acceptable quality, a result which is clearly inconsistent with comfort care goals.

Furthermore, near the end of life, patients may either not wish to undergo CPR or CPR may not be medically appropriate, therefore it becomes appropriate to consider ICD tachyarrhythmia’s therapy deactivation when the patient’s clinical status worsens and death is near.

In the end of life setting, discussions about deactivating ICD tachyarrhythmia’s therapy should take place as early as appropriate to enable proactive care management to avoid unnecessary distress. Although deactivation is not a complicated process, it may only be possible at certain times, because of the specific programmer required and technician support, therefore early planning is required.

Criteria for deactivating a defibrillator should be discussed with a patient and/or their next of kin when resuscitation issues are explored or when a patient’s condition is worsening and deactivation may be appropriate. Ideally, discussions should take place while the patient is still able to be involved in the decision making process. If this is not possible, discussions should take place with the next of kin and/or Health and Welfare Lasting Power of Attorney, taking into account the known wishes of the patient, ongoing medical treatments, and, if available, the details from an advance healthcare directive alongside consideration of what decision would be in the patient’s best interest.

When discussing the expectations of deactivating ICD tachyarrhythmia’s therapy, the following should be made clear:

1. The device will no longer provide lifesaving therapy in the event of a ventricular tachyarrhythmia.
2. Turning off the device will not cause death.
3. Turning off the device will not be painful, nor will its failure of function cause pain.
4. There will be a plan of care to ensure healthcare professional availability to address new questions or concerns.
5. The ICD will continue to provide bradycardia pacing should the patient need it.
6. The decision to deactivate the device can be reversed if the clinical situation changes. i.e. this is **not** an irreversible decision.
7. A deactivation request form will need to be completed.

ICD deactivation process can be seen in Appendix F. Further information can be found on the Cardiology intranet site under the Physiology Resource tab, or by contacting the Wiltshire Cardiac Centre (Ref 15).

## Communicating Decisions to Other Health Care Providers

The person who makes a TEP/ Resuscitation decision is responsible for ensuring that the decision is communicated effectively to other relevant healthcare professionals in both primary and secondary care. The senior nurse is responsible for ensuring that every TEP/ Resuscitation decision is recorded in the patients notes and that all those nursing the patient are aware of the decision.

Any decisions about resuscitation measures must be communicated between healthcare professionals whenever a patient is transferred between establishments, between different areas or departments of one establishment, or is discharged.

A TEP Alert must be requested as soon as the decision record has been completed. This can be done by sending an email to [Tep.ResusDecision@gwh.nhs.uk](mailto:Tep.ResusDecision@gwh.nhs.uk) with the patient’s details: Name, hospital number, NHS number, date of birth with a note stating that a TEP has been completed for this patient.

Clinical guidelines issued by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) (Ref 22) (the Mental Capacity Act 2005 Policy and Procedures (Ref 3) ***advise ambulance employees that they should always initiate CPR unless:***

* There is a formal TEP/DNAR decision, or valid and applicable advance decision made by the patient, which has been seen by the ambulance crew, and the circumstances in which CPR may be attempted are consistent with the wording of the DNAR decision or advance decision;

Or

* The patient is known to be terminally ill and is being transferred to a palliative or terminal care facility (unless specific instructions have been received that CPR should be attempted).

## Relatives Witnessing Resuscitation

If the patient’s relative(s) requests to witness a resuscitation attempt it is the decision of the team leader and others present as to whether this is safe and appropriate.

Under no circumstances should a relative be left unsupported or unsupervised whilst witnessing a resuscitation attempt. It is essential that they are given the correct support and allowed the opportunity to leave or return when they feel it necessary.

Under no circumstances should relatives be coerced or encouraged to witness resuscitation if they have requested not to.

## Discharge and TEP/ Resuscitation Decision

Prior to discharge the content of the TEP decision record should be reviewed and once the patient and/or family/carers are informed about its contents, the original decision record should accompany the patient. The lead clinician must ensure that discussions with the patient and family regarding the scope and content of the TEP decision record are documented clearly in the medical notes.

The discharging doctor must ensure a photocopy of the TEP decision record remains in the patient’s notes and that the TEP decision is communicated to the GP in the discharge letter, and an Alert has been set up on the patients’ electronic record. If the family or patient/carer refuses to take the TEP decision record home the original document should be kept in the patients notes and the GP informed as to the reasons why the document did not accompany the patient.

## The Dying Patient

There will be instances when the healthcare team recognises that a patient is dying, or will go on to die within hours or days. At this stage the need for interventions such as analgesia, relief of distress, hydration, nutrition and other medications will need to be reviewed.

An appropriate TEP decision record should now be completed alongside the Trust’s End of Life Care Strategy (Ref 17) and any relevant care of the dying care plans must be completed to ensure comfort, dignity and support for the patient and their family/carer during this difficult time.

## Care after Death

After the patient’s death the Trust’s Care of the Dying and Deceased Policy (Ref 18) must be used to ensure continuation of high quality care and provide appropriate support and information to relatives.

All beliefs of the patient or family must be respected during this process.

# Duties and Responsibilities of Individuals and Groups

## All Clinical Employees

All clinical employees are responsible for:

* Participating in the development and consultation process where appropriate.
* Gaining appropriate training and support with regards to the conversations that may be had with patients and relatives regarding TEP and resuscitation decisions.
* Being receptive to the needs of patients and relatives/carers with regards to resuscitation discussions and, where necessary, facilitating appropriate healthcare professionals to address patients’/relatives’ concerns and worries and to aid in supporting others with regards to the decision making process.
* Making themselves aware of and understanding this policy and how it relates to their practice in regards to a “TEP/Resuscitation Decision” as well as any supporting documents that relate to their role and responsibilities.
* Complying with this policy.
* Ensuring that all patients’ records reflect an up to date TEP plan, and that all employees are constantly aware of this plan.
* Reporting incidents of non-compliance with this policy and supporting documents. This should be carried out in line with the Trust’s agreed Incident Management Policy (Ref 16).

## Ward Employees

Ward employees (including nursing, Allied Health Professionals (AHP) and administrative employees) are responsible for:

* Having an awareness of this policy,
* Being familiar with TEP documentation,
* Sharing information on resuscitation status across team members,
* Ensuring the correct filing of the document or copy document in the patients’ medical notes.

## Doctors in Training

Doctors in training are responsible for:

* Understanding the implications of this policy,
* Ensuring Consultant ratification of any resuscitation decisions and that such ratification is recorded including Consultant signature on the Trust approved TEP/Resuscitation Decision document.

## Nurse Practitioners

Nurse Practitioners, Specialist Nurses and Resuscitation Training Leads are responsible for:

* Ensuring sharing of any resuscitation or escalation of treatment decisions made across the multidisciplinary team within individual wards or departments,
* Sharing decisions supported by documentation when patients are required to attend or receive treatment in other departments within the Trust.
* Ensuring all new employees joining the Trust are made aware of this policy and other supporting documentation.

## Consultants

Consultants are responsible for:

* Recognising when the TEP/ Resuscitation process should be instigated. They may also be approached by patients regarding TEP/Resuscitation decisions.
* Encouraging the start of the conversations with patient / relatives/carers to agree an appropriate plan, and completing the appropriate form at an early stage for those patients in whom TEP is appropriate.
* Ensuring that an Alert is requested or removed on Medway (PAS) as appropriate.

# Monitoring Compliance and Effectiveness of Implementation

The arrangements for monitoring compliance are outlined in the table below:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Measurable policy objectives** | **Monitoring / audit method** | **Monitoring responsibility** (individual / group /committee) | **Frequency of monitoring** | **Reporting arrangements** (committee / group to which monitoring results are presented) | **What action will be taken if gaps are identified?** |
| 100% compliance with the TEP / Resuscitation Decision document compliance against policy | TEP/ Resuscitation Decision Documentation Audit | Resuscitation Department/ Clinical Audit | Annual | Resuscitation Committee  Clinical Managers  Medical/ Nursing Director | Action plan written and communicated to relevant employees. Review education and training associated with this issue. Re-audit of non-compliant areas |
| 100% Employees awareness of TEP/Resuscitation Decision Policy gained from mandatory training and induction. | TEP Policy Employees Awareness Questionnaire | Resuscitation Department | Annual | Resuscitation Committee  Clinical Managers  Medical/ Nursing Director | Action plan written and communicated to relevant employees. Review education and training associated with this issue. Re-audit of non-compliant areas |
| Monthly reporting to GPs informing them of the current list of patients that are registered as having a TEP Alert on the Medway (PAS) system, | Monthly Report emailed to GPs from Medway | GPs to inform Lead for TEP Alerts of Incorrect entries | Monthly | Resuscitation Committee | Investigate any incorrect entries and review. To add any missing patients from GP return. |

## Monitoring and Assurance

The Trust will collate and review documentary evidence of compliance with medical standards set out by the Care Quality Commission (CQC) through its Trust assurance process. Assurance will be provided if compliance and any gaps are identified in the form of action plans and feedback to relevant management

# Review Date, Arrangements and Other Document Details

This Policy will be reviewed every three years or sooner if legislation/clinical practice changes. Patient feedback will be taken into consideration. Local audit andevaluation will be undertaken.

## Regulatory Position

Resuscitation Council (UK) Resuscitation Guidelines 2010.

## References, Further Reading and Links to Other Policies

|  |  |  |
| --- | --- | --- |
| Ref. No. | Document Title | Document Location |
| 1 | Decisions relating to cardiopulmonary resuscitation” A joint statement from the British Medical Association, The Resuscitation Council UK, and The Royal College Of Nursing. Oct 2014 | www.resus.org.uk |
| 2 | Mental Capacity Act 2005 Policy and Procedures | Intranet |
| 3 | Mental Capacity Act 2005: Code of Practice (2007) | www.legislation.gov.uk |
| 4 | Resuscitation Policy | Intranet |
| 5 | Identification, Referral and Approach to Families of Potential Organ and Tissue Donors Policy | Intranet |
| 6 | General Medical Council - Treatment of Care Towards the End of Life | [www.gmc-uk.org/guidance](http://www.gmc-uk.org/guidance) |
| 7 | Department of Health – End of Life Care Strategy Forum Annual Report Oct 2012 | [www.gov.org](http://www.gov.org) |
| 8 | Royal College of Physicians - Concise Guidance to Good Practice, Number 12. Advanced COE Planning National Guidelines (2009) | [www.cplondon.ac.uk](http://www.cplondon.ac.uk) |
| 9 | NICE- Rationale, Scope and Further Information of the End of Life care in adults, quality standard | [www.nice.org.uk](http://www.nice.org.uk) |
| 10 | The College of Emergency Medicine “End of Life care for adults in the emergency department Best Practice Guide (Feb 2012) | www.collemergencymed.ac.uk/ |
| 11 | Resuscitation Guidelines, Resuscitation Council (UK) 2010 | [www.resus.org.uk](http://www.resus.org.uk) |
| 12 | NHS Improving Quality, “The route to success - transforming end of life care in acute hospitals 20 June 2010 - National End of Life Care Programme” | http://www.nhsiq.nhs.uk |
| 13 | Dying Matters (2015) | http://www.dyingmatters.org |
| 14 | Sign up today Organ donation | https://www.organdonation.nhs.uk |
| 15 | Wiltshire Cardiac Centre | Intranet. Unscheduled Care pages. |
| 16 | Incident Management Policy | Intranet |
| 17 | Great Western Hospital End of Life Care Strategy 2015-2018 | Intranet |
| 18 | Care of the Dying and Deceased Policy | Intranet |
| 19 | The Human Rights Act 1998 | http://www.legislation.gov.uk |
| 20 | Cardiopulmonary Resuscitation CPR patient leaflet | Intranet |
| 21 | Resuscitation Department Paediatric Do Not Attempt resuscitation Forms and guidance | Intranet |
| 22 | UK Ambulance Services Clinical Practice Guideline | <http://www.jrcalc.org.uk> |
| 23 | PAS/EPR Patient Alert Policy | Intranet |
| 24 | The Second Annual Report of the End of Life Care Strategy (DH, 2010) | <https://www.gov.uk/government/publications/end-of-life-care-strategy-second-annual-report> |
| 25 | Gov. UK Make, register or end a lasting power of attorney (2015) | <https://www.gov.uk/power-of-attorney/overview> |
| 26 | Mental Capacity Act (2005) | <http://www.legislation.gov.uk/ukpga/2005/9/contents> |
| 27 | Paediatric Resuscitation Policy | Intranet |

## Consultation Process

The following is a list of consultees in formulating this document and the date that they approved the document:

| **Job Title / Department** | **Date Consultee Agreed Document Contents** |
| --- | --- |
| Academy Manager / Academy | 12.05.2015 |
| Cardiac Services GWH | 12.07.2015 |
| Clinical Governance | 05.06.2015 |
| Consultant and Chair of Resuscitation Committee / ICU | 08.06.2015 |
| Divisional Manager | 04.06.2015 |
| EDS System user Group | 05.05.2015 |
| End of Life Programme Board | 17.07.2015 |
| Infection Prevention and Control | 12.07.2015 |
| IT services GWH | 04.06.2015 |
| Mortuary & Bereavement Services | 12.07.2015 |
| Patient Information Group HUG | 29.06.2014 |
| Patient information groups, Swindon Health watch, | 01.06.2014 |
| Patient Record Committee | 14.04.2015 |
| Patient Safety Governors meeting | 03.03.2015 |
| Resuscitation Officers / Academy | 12.05.2015 |
| South West Ambulance Services | 17.07.2015 |
| Swindon CCG Executive Nurse | 07.07.2015 |
| Transplant Lead GWH | 23.09.2014 |
| Unscheduled Care Division | 04.06.2015 |
| Wiltshire Care Home Forum | 14.04.2015 |
| Wiltshire CCG End of life Programme Board | 17.07.2015 |

# Appendix A – Equality Impact Assessment

**Equality Impact Assessment**

**Our Vision**

Great Western Hospitals NHS Foundation Trust wants its services and opportunities to be as accessible as possible, to as many people as possible, at the first attempt.

**Are we Treating Everyone Equally?**

Define the document. What is the document about? What outcomes are expected?

Consider if your document/proposal affects any persons (Patients, Employees, Carers, Visitors, Volunteers and Members) with protected characteristics? Back up your considerations by local or national data, service information, audits, complaints and compliments, Friends & Family Test results, Staff Survey, etc.

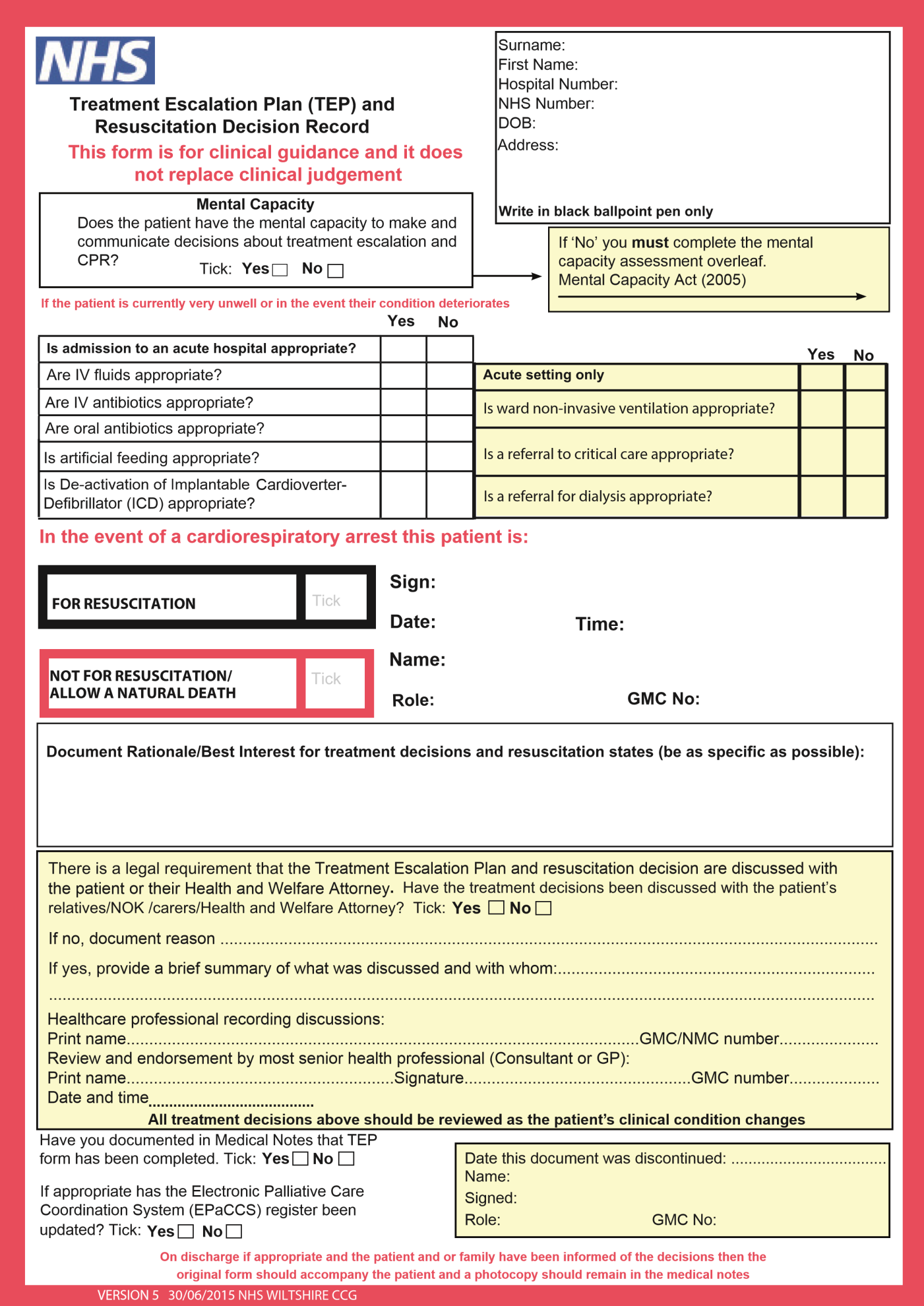
If an adverse impact is identified what can be done to change this? Are there any barriers? Focus on outcomes and improvements. Plan and create actions that will mitigate against any identified inequalities.

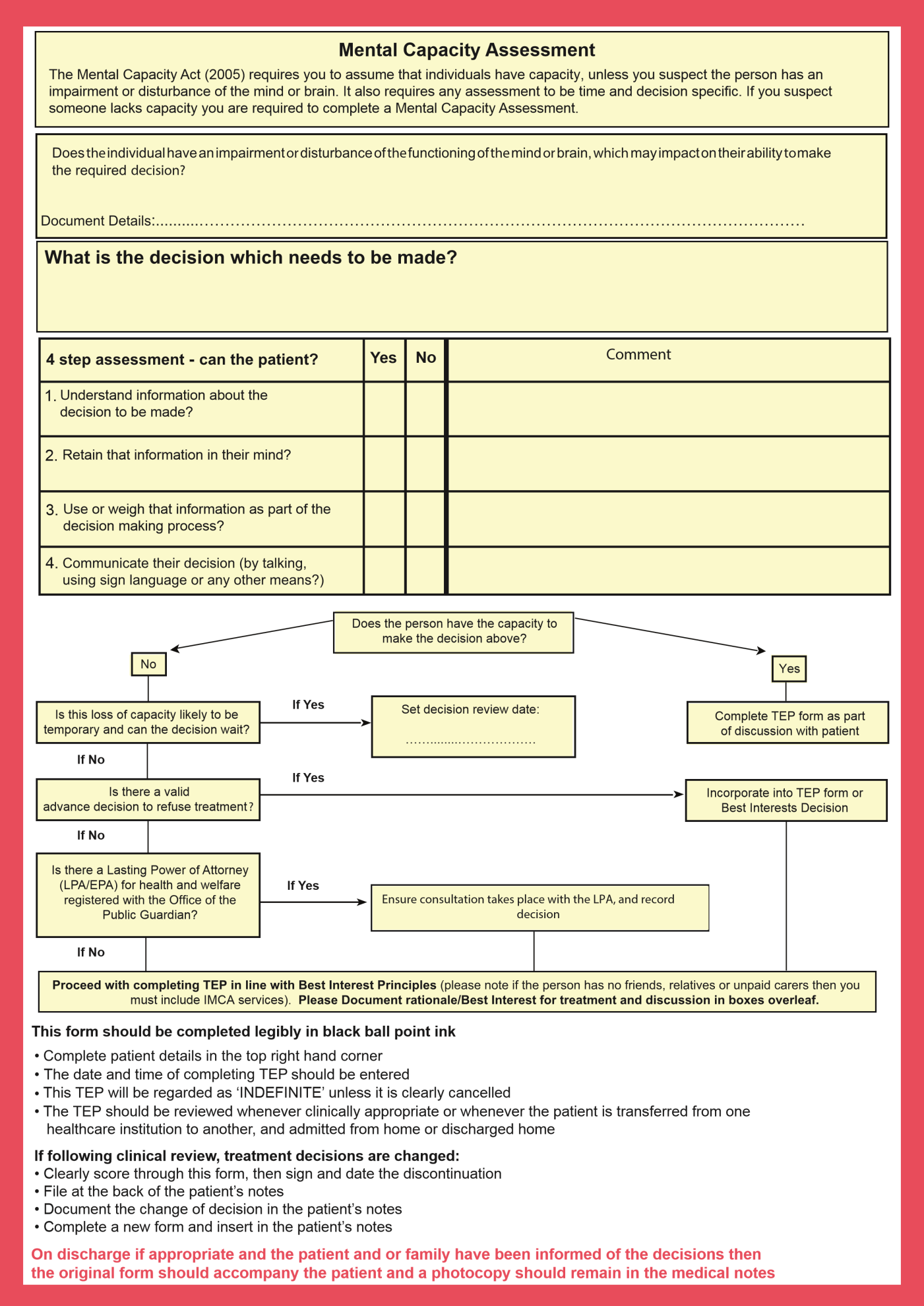
If the document upon assessment is identified as having a positive impact, how can this be shared to maximise the benefits universally?

# Appendix B – Quality Impact Assessment Tool

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Purpose**  To assess the impact of individual policies and procedural documents on the quality of care provided to patients by the Trust both in acute settings and in the community. | | | | | | | |
| **Process**  The impact assessment is to be completed by the document author. In the case of clinical policies and documents, this should be in consultation with Clinical Leads and other relevant clinician representatives.  Risks identified from the quality impact assessment must be specified on this form and the reasons for acceptance of those risks or mitigation measures explained. | | | | | | | |
| **Monitoring the Level of Risk**  The mitigating actions and level of risk should be monitored by the author of the policy or procedural document or such other specified person.  High Risks must be reported to the relevant Executive Lead. | | | | | | | |
| **Impact Assessment**  Please explain or describe as applicable. | | | | | | | |
| 1. | Consider the impact that your document will have on our ability to deliver high quality care. | *This policy outlines the protocol for the making and recording of a Treatment Escalation Plan (TEP) and Cardio Pulmonary Resuscitation (CPR) Decision, to ensure effective communication of decisions made) and to support a patient centred, holistic approach to patient’s care.* | | | | | |
| 2. | The impact might be positive (an improvement) or negative (a risk to our ability to deliver high quality care). | | | | *To encourage early patient participation and discussion with regards to end of life decision, and allowing patient to be part of their final treatment options.* | | |
| 3. | Consider the overall service - for example: compromise in one area may be mitigated by higher standard of care overall. | | | | | *N/A* | |
| 4. | Where you identify a risk, you must include identify the mitigating actions you will put in place. Specify who the lead for this risk is. | | | | | *N/A* | |
| **Impact on Clinical Effectiveness & Patient Safety** | | | | | | | |
| 5. | Describe the impact of the document on clinical effectiveness. Consider issues such as our ability to deliver safe care; our ability to deliver effective care; and our ability to prevent avoidable harm. | | *TEP will encourage clinicians to discuss EOL wishes sooner, improving patient experience, as patients will be involved in the discussions and will be in a position to transfer any decision and paperwork to other healthcare providers within the Swindon and Wiltshire CCG’s. This will allow time for patient to make an informed decision on their own EOL care and reduce inappropriate hospital admissions and resuscitation attempts.* | | | | |
| **Impact on Patient & Carer Experience** | | | | | | | |
| 6. | Describe the impact of the policy or procedural document on patient / carer experience. Consider issues such as our ability to treat patients with dignity and respect; our ability to deliver an efficient service; our ability to deliver personalised care; and our ability to care for patients in an appropriate physical environment. | | | *Improved efficiency, patient and carer communication will have an overall positive impact on our patients experience by allowing them to plan and conceder their EOL wishes at a less critical point in their illness. The TEP document is now recognised County wide which means that decisions made in either Primary or Secondary care will be used appropriately to guide clinician’s decisions without the distress of further in depth discussions with patients and relatives.* | | | |
| **Impact on Inequalities** | | | | | | | |
| 7.  EOL/TEP Conversation with patient/ relative as appropriate | Describe the impact of the document on inequalities in our community. Consider whether the document will have a differential impact on certain groups of patients (such as those with a hearing impairment or those where English is not their first language). | | | | | | N/A |

# Appendix C – Treatment Escalation Plan (TEP) and Resuscitation Decision Record





# Appendix D - Guidance for Completing Treatment Escalation Plan and Resuscitation Decisions (leaflet)

* This form should be completed legibly in black ball point pen.
* Complete patient details (including address)

**Life Expectancy**

The Second Annual Report of the End of Life Care Strategy (DH, 2010) (Ref 24) recognised the challenge of identifying who is approaching end of life, and acknowledged that we need to do more to improve the present situation. One of its recommendations was the adoption of the ‘surprise question’, where a health professional asks themselves, ‘Would I be surprised if this patient were to die within the next 6–12 months?’ If the answer is no it should lead the professional to consider completing the TEP&RD form. When completing this form it is important that the healthcare professional has knowledge of end of life procedures and documents. If in doubt refer to your organisation’s End of Life Policy.

**Healthcare professional making the TEP&RD**

Ideally the TEP&RD should be made by the most senior medical clinician looking after the patient. However, if a more junior member of staff is completing the form it must be in consultation with their registrar or consultant, and documented as such in the medical notes. The form should be countersigned by the Consultant/GP at the earliest opportunity.

**TEP&RD review**

A fixed review date is not recommended, the TEP is considered as “infinite” unless cancelled. The order should be reviewed whenever clinically appropriate, whenever the patient is transferred from one healthcare institution to another and whenever the patient is admitted to a GWH site or discharged home.

**Capacity/advance decisions**

If there is any reason to doubt the mental capacity of the patient, a Metal Capacity Assessment must be completed. The two stage Mental Capacity Test is on the back of the form. This assessment is only relevant to the decisions made in relation to TEP&RD, and only at the time of the assessment. If capacity changes, the whole form must be reviewed, and a new TEP&RD completed. Clearly document any best interest decision in relation to the TEP&RD. For further information and guidance please refer to your local multiagency safeguarding policy and procedure and the ‘Mental Capacity Act 2005 Code of Practice’ (2007).

**Summary of communication with patient**

State clearly what was discussed and agreed, when and with whom. If this decision was not discussed with the patient state the reason why. It is good and recommended practice to discuss treatment decisions with every patient but if this would cause distress without any likelihood of benefit for the patient, or if the patient lacks capacity, this should be recorded.

**Summary of communication with patient’s relatives or friends**

If the patient does not have capacity their relatives, friends or an IMCA must be consulted and may be able to help by indicating what the patient would decide if able to do so. If the patient has made a Health & Welfare Lasting Power of Attorney (HWLPA) to make health-related decisions on their behalf, the doctor must ensure that the HWLPA is valid before consulting them. A HWLPA may be able to refuse life-sustaining treatment on behalf of the patient if this power is included in the original HWLPA document. That person will make decisions as if they are the patient themselves. All their decisions must be in the patient’s best interest. If it is felt the HWLPA is not acting in the patient’s best interest the Office of the Public Guardian must be informed along with the local Safeguarding Team. Ensure that discussion with others does not breach confidentiality. State the names and relationship of relatives and friends or other representatives with whom this decision has been discussed. More detailed description of such discussion should be recorded in the clinical notes. For further guidance on Best Interests Principles see overleaf.

**Members of multidisciplinary team**

Ensure that the TEP&RD has been communicated to all relevant members of the multidisciplinary health and social care teams involved in caring for the patient.

**Communication across other healthcare settings**

For TEP&RD or End of Life patients, the original of this form should accompany the patient on transfer if appropriate. This document remains valid until reviewed/endorsed by the receiving healthcare professional.

**Discharge and TEP&RD**

Prior to discharge the content of the form should be reviewed and, if the patient and/or family are informed about its contents and it is relevant to the clinical situation, the original form should accompany the patient. Ensure conversations with the patient and family regarding this are documented. Ensure a photocopy of the form remains in the notes and it is communicated to the GP in the discharge letter. Ensure that Ambulance/Transport staff are aware of the TEP&RD before transfer.

**Organ donation**

Patient and family wishes regarding organ/tissue donation after death should be ascertained and documented. It is essential for staff to establish if the patient has previously expressed the wish to be a donor; and if the patient is on the NHS Organ Donor register or carries a Donor Card. Please refer to your organisation’s guidelines relating to organ donation.

**If, following clinical review, TEP&RD are changed:**

* Clearly score through this form, then sign and date the discontinuation box in the lower right hand corner of the front page.
* File the scored-through form at the back of the patient’s notes.
* Document the change of decision in the patient’s notes.
* Complete a new form and insert a photocopy in the patient’s notes, give the original to the patient/relatives as appropriate.

# Appendix E -The Process for Making Best Interest Decisions in Serious Medical Conditions in Patients Over 18 years

Start by assuming that the person has capacity. If there is doubt, proceed to the two stage test of capacity:   
**Stage 1**: Does the person have an impairment of, or a disturbance in, the functioning of their mind or brain?

**Stage 2**: Does the impairment, or disturbance, mean that the person is unable to make a specific decision when they need to?

Their capacity to make this decision should be assessed by four functional tests:

**1. Can they understand the information?** This must be imparted in a way the patient can understand.   
**2. Can they retain the information?** This only needs to be long enough to use and weigh the information.  
**3. Can they use or weigh up the information?** They must be able to show that they are able to consider the benefits and burdens of the alternatives to the proposed treatment.   
**4. Can they communicate their decision?** Every adjustment possible should be made to enable this i.e. use of an interpreter, providing a pen and paper.

The result of each step of this assessment should be documented, ideally by quoting the patient.

Ask the patient.   
NB. An eccentric or unwise decision does not imply a lack of capacity.

**YES**

Does the patient have the capacity to make this decision for themselves?

• **If the ADRT is the most recent decision:**   
- Check that the circumstances of the ADRT match the current circumstance and that the ADRT is valid and applicable.  
- This ADRT then overrides any previous ADRT or HWLPA appointment.  
- Follow the decision(s) stated in the ADRT.

**• If the appointment of a HWLPA is the most recent decision:**- Check with the Office of the Public Guardian that it has been registered and includes the authority to decide on serious medical conditions.  
- The HWLPA then overrides any previous ADRT or LPA appointment.  
- Fully inform the HWLPA of the clinical facts.  
- Ask the HWLPA for their decision.  
NB. There may be more than one HWLPA.

**NO**

If there an Advance Decision to Refuse Treatment (ADRT) and/or a Health and Welfare Lasting Power of Attorney (HWLPA) in place?

**YES**

**NO**

**YES**

Is the patient without anyone who could be consulted about their Best Interests?

• In an emergency, act in the patient’s Best Interests (see below).  
• For any other serious medical decisions, involve an Independent Mental Capacity Advocate (IMCA) which are available locally.

**NO**

**• Appoint a decision maker (usually after an interdisciplinary team discussion) who should:**   
- Encourage the participation of the patient.  
- Identify all the relevant circumstances.  
- Find out the person’s views (i.e. wishes, preferences, beliefs and values); these may have been expressed verbally previously, or exist in an ADRT or Advanced Care Plan made when the patient had capacity.  
- Avoid discrimination and avoid making assumptions about the patient’s quality of life.   
- Assess whether the person may regain capacity.  
- If the decision concerns life-sustaining treatment, not be motivated in any way by a desire to bring about the patient’s death.   
- Consult others (within the limits of confidentiality): This may include an HWLPA, IMCA or Court Appointment Deputy.  
- Avoid restricting the person’s rights.  
- Take all of this into account (i.e. weigh up all these factors in order to work out the person’s Best Interests).   
**• Record the decisions.  
• Agree review dates and review regularly.**

* Complete patient details (including address) or affix patient’s identification sticker

If there is unresolved conflict, consider involving:   
- The Local Ethics Committee.  
- The Court of Protection, possibly through a Court Appointment Deputy (CAD).

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# Appendix F– Flow Chart for Deactivation of ICDs

Out Patient

In Patient

On death of patient:

* Request return of home monitor box if applicable.
* Discontinue patient’s home monitoring on website.
* Discharge patients from Pacing Clinic / Virtual Follow up.
* Close patient file on CVIS.

Decision made by Consultant or G.P. in discussion with patient.

TEP Documentation completed, decision documented in patient’s notes.

Once ICD is disabled email patient’s Consultant informing them of completion. Consultant to inform Cardiology department when patient dies.

FLOWCHART FOR DEACTIVATION OF ICDS

Disable ICD - turn off detection monitor zone - therapies off –shocks off – ATP off – all other patient alarms/alerts off.

Cardiologist or Physiologist to check request has been documented in patient’s notes.

Cardiologist / Physiologist to interrogate the device and store all information.

Cardiologist or Physiologist response - aim to deactivate ICD within 48 hours.

Cardiology request entered via CVIS system.

Request from G.P. or Doctor looking after patient / Prospect Nurse.

Telephone referrals to be completed on ICD Request form and faxed back. This to be scanned into CVIS System.

Request must be in a traceable format, email or hard copy, and signed on headed paper or stamped with Institution stamp.